## For Discharge Planning from ICF/ID and Enrolling in the MR/RD Waiver Program

Provider Name:			
Provider Number	:		
Provider's Addres	ss:		
	Invoice Number:		
	who are preparing for discharge mus may be received for up to six (6) mon		
	SERVICE COORDINATION SE	RVICES PROVIDED	
MONTH OF SERVICE	CONSUMER'S NAME	SSAN	AMOUNT (\$)
accordance with	TIFICATION: All units of services DDSN's guidelines as stated in DDSN se Leaving ICFs/ID and Enrolling in I	I directive 738-01-DD: Disch	arge
bused warvers			
Signature			